DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445136	A. BUILDING 03 - MASTERS HEALTH CARE B. WING _____	07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-MASTERS	278 DRY VALLEY RD ALGOOD, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on testing, it was determined the facility failed to maintain the negative pressure in required areas. The finding included: Testing of the basement biohazard room on 7/10/12 at 9:40 AM, revealed positive air pressure. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/10/12.	K 067	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K067 It is the practice of this facility to ensure the heating,, ventilating and air conditioning comply with the provisions of section 9.2 and are installed in accordance with manufacturer's specifications. A licensed heating, cooling, ventilation contractor has been retained, proposal submitted and approved to install the necessary equipment to correct and establish a negative pressure airflow in the soiled utility room on the G wing. The work is scheduled to be completed by July 31, 2012. Maintenance supervisor on 7/10/12 checked the air flow in all other soiled utility rooms and are operating and maintaining a negative airflow as required. Maintenance supervisor will include monitoring air flow and equipment operation for proper ventilation in dirty utility rooms as part of the facility monthly Preventative Maintenance Program and will document such on the facility PM logs. The Maint. Supervisor will include reporting on ventilation/negative air flow in his Preventative Maintenance Report monthly to the facility Performance Improvement Committee meeting for review, discussion and recommendations, if indicated.	8/3/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sylvia J. Burton
TITLE: Executive Director
(X6) DATE: 7/30/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.